MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Edward Wolski, M.D. / Wol+Med 2436 I-35 South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-8869-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 39 Lumbermens Mutual Casualty Co. c/o Flahive Ogden & PO Box 13367 Austin TX 78711	Date of Injury: Employer's Name: Georgia Pacific Corporation Insurance Carrier's No.: A26460476100010164

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
9/19/02	9/24/02	99203, 72110-WP, 97139-PH, 99070, 95831-MT, 97024,97032,	$651.00	$259.00

PART III: REQUESTOR'S POSITION SUMMARY

DATE: 8/11/03 "…Our position regarding the denials are as follows: 1) DOS 9/19/02 – 9/24/02 – the carrier failed to respond to our initial billing as per… carrier failed to respond again…However, we have now received our first notice from the carrier regarding these DOS, and they incorrectly denied payment…with "D" for duplicate billing…"

PART IV: RESPONDENT'S POSITION SUMMARY

DATE: A response was not received by TWCC-MDR from the Respondent in reference to this medical reimbursement dispute.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 7/24/03, MDR received the Requestor's request for reimbursement of treatment/services rendered from 9/19/02 through 9/24/02 to the injured worker.
- The Requestor provided convincing evidence that the HCFA's were submitted for reimbursement and reconsideration to the Respondent according to 133.304(k).
- According to Rule 133.304 (l), the Respondent did not respond to the reconsideration request.
- After review of the information received the following conclusions have been determined:

  According to 133.304 (c), the Respondent did not provide explanation to allow the sender to understand the reason for the lack of payment. Therefore the disputed DOS will be reviewed for fee issues and reimbursed according to the 1996 MFG / MAR. Reimbursement recommended as follows:

DOS	CPT Code		Amount due:
9/19/02:	99203	Convincing evidence submitted to support services rendered	$74.00
	72110-WP	($22.00+$34.00) Report attached.	$56.00
	97139-PH	(DOP) Rule 133.307 (g)(3)(D) was not supported.	$ 0.00

	99070	(DOP) Rule 133.307 (g)(3)(D) was not supported.	$ 0.00
	95831-MT	Report not received for review according to CPT descriptor.	$ 0.00
	97024	Convincing evidence submitted to support services rendered	$21.00
	97032	Convincing evidence submitted to support services rendered	$22.00
9/20/02:	95851	Report not received for review according to CPT descriptor	$ 0.00
	99070	(DOP) Rule 133.307 (g)(3)(D) was not supported	$ 0.00
	97024	Convincing evidence submitted to support services rendered	$21.00
	97032	Convincing evidence submitted to support services rendered	$22.00

97110 Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

9/21/02:	97139-PH	(DOP) Rule 133.307 (g)(3)(D) Convincing evidence in the clinical notes did not support services were rendered.	$ 0.00
	99070	(DOP) Rule 133.307 (g)(3)(D) Convincing evidence in the clinical notes did not support services were rendered.	$ 0.00
	97024	Convincing evidence submitted to support services rendered.	$21.00
	97032	Convincing evidence submitted to support services rendered.	$22.00
9/24/02:	97139-PH	(DOP) Rule 133.307 (g)(3)(D) was not supported in clinical notes.	$ 0.00

TOTAL DUE: **$259.00**

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $259.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Authorized Signature	Name	7 / 7 / 05 Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____